FACE INVESTIGATION

SUBJECT: Paper mill worker dies after falling 15.5 feet down a vertical conveyor

SUMMARY:

A 33 year old white female "helper" who worked for 2 years on a roll paper processing machine fell 15.5 feet down a vertical conveyor. It is not clear if the worker stepped over the sensing beam and entered the vertical conveyor to remove scrap paper or if the victim became caught by the conveyor gate and tray and was pulled in and then down the vertical conveyor. The worker had worked at the company 2 and one-half years. The incident occurred in the early AM near the end of the shift. No one witnessed the incident. The victim was pronounced dead approximately 1 hour after being found at the bottom of the conveyor shaft. CPR was attempted by trained workers at the site. The Wisconsin FACE investigator concluded that, in order to prevent similar occurrences, the employer should:

! Survey the work-site to identify hazards. All employees should then be informed of the possible hazards.

! Consider and address worker safety in the planning phases of projects.

! Implement 29CFR 1910.261 (b) (4), which requires lockout before entering machinery.
! Provide feed guarding that cannot be bypassed by operators.

INTRODUCTION:

On November 4, 1991 a 33 year old helper on a roll processing machine in a paper mill died after falling 15.5 feet down a vertical conveyor. The Wisconsin FACE investigator was notified by the Wisconsin Department of Labor and Human Relations, Safety and Buildings Division on November 14, 1991. On November 15, the WI FACE field investigator and a DILHR safety inspector investigated the incident. A death certificate, workers compensation claim, coroner report, and OSHA report were obtained. The employer was interviewed.

The company has been in operation for 100 years and employs 600 people. Eight persons have the same job title as the victim. There is a full time safety officer and workers are offered general training. The company has a written lockout and tagout program. The program had not been fully implemented, it was not intended to cover this job task. There had been a warning sign on the conveyor at one time, it had been removed during painting.

INVESTIGATION:

On the morning of November 4, 1991, the victim was working on the conveyance used to lower paper rolls calendar to a lower level. No one witnessed the incident. It is surmised that the worker stepped into the vertical conveyor to tape the roll. The elevator door swung shut with the worker inside and the lower-drop function proceeded automatically causing the worker to fall down the shaft. The worker was then caught

in the movement of the conveyor machinery which caused her death. A co-worker found the victim shortly after 5:20 AM at the bottom of the elevator shaft. The CPR certified company supervisor found no pulse, CPR was begun, the local emergency squad was called and arrived within 15 minutes. The victim was transported to an area hospital in Michigan where she was pronounced dead at 6:34 AM.

CAUSE OF DEATH: The coroner reported the cause of death, massive internal injuries sustained in an accidental fall.

RECOMMENDATIONS/DISCUSSION:

Recommendation #1: Conduct a jobsite survey before starting any job to identify potential hazards. Implement appropriate control measures including training that specifically addresses all identified safety hazards.

Recommendation #2: Employers should address worker safety issues in the planning phase of all projects and must re-address issues if machinery or processes are altered.

Recommendation #3: Install adequate guarding so that it is impossible for a worker to enter the material carrier during the operating cycle. With the current system the worker can defeat the photo cell safety device by reaching or stepping over it. The gate guard and the photo cell safety device could be overridden by a cycle pause switch that had been hardwired into output mode only, which could cause auto cycle to resume without warning and delay.

Recommendation #4: Implement 29 CFR 1910.261 (b) (4). At the loading point, lockout was not used prior to entry into the automatic discharge area to retrieve paper or retape rolls or other cleaning and adjusting. Re-training of workers in needed so that they understand that this is an area where lockout does apply.